DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085029	A. BUILDING _____ B. WING _____	C 12/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON HOUSE OF GEORGETOWN	110 W. NORTH STREET GEORGETOWN, DE 19947

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F 000	INITIAL COMMENTS An unannounced, annual survey and complaint visit was conducted at this facility from December 6, 2011 through December 14, 2011. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred-two (102). The survey sample totaled forty (40) residents	F 000	**Disclaimer** Preparation and/or execution of the Plan of Correction does not constitute an admission or agreement by the provider or the provider's employees as to the truth of the allegations in the Statement of Deficiencies. The Plan of Correction is offered in mandatory compliance with the provisions of state and federal law. The corrective actions are implemented as remedial measures pursuant to law.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to ensure that one resident (R35) out of 40 sampled was free from restraints when they failed to identify bolsters as a restraint and imposed the restraints for the purposes of staff convenience. Findings include: The facility policy and procedure for Restraint Devices -"Restraints of any type will not be used as punishment or as a substitute for more effective medical and nursing care for the convience of the facility staff. -Physical restraints are defined as any manual method or physical or mechanical device,	F 221	**Date of Compliance -1/23/12** **F-tag 166 Grievances** 1. A thorough investigation into the Resident #75 broken vase was conducted by social service and the outcome was reviewed with the resident to ensure resolution of the problem. 2. The QI Director and Director of social services met with the resident group to review reporting procedures for lost, stolen or broken personal items. No new or additional items were identified for investigation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 1/16/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." R35 was admitted to the facility with diagnoses that included cerebral vascular accident, hypertension, dysphasia, seizure disorder and diabetes mellitus. The annual MDS dated 12/7/11 for R35 documented he was totally dependent with one person to physically assist him for his bed mobility. The MDS also assessed R35 as having 2 side rails as a restraint in bed. The facility failed to identify on the MDS the bolsters as under "other" as a restraint. The December 2011 monthly physician orders for R35 revealed an order for "1/2 side rails special instructions: 1/2 Side rail up times 2 as safety measure related to poor trunk control and poor posture in bed." R35 had a care plan for fall risk adding as an approach bed bolsters, bed/chair clip alarm, low bed, floor mat door side. However, the facility failed to develop a care plan for the 2-1/2 side rails identified by the facility as restraints. A side rail screen was completed for R35 on 12/4/11. The side rail screen documented R35 was non ambulatory, had a history of falls, had poor bed mobility difficulty moving to sitting position on the side of the bed, difficulty with balance or poor trunk control, taking medications which required increased safety precautions, used the side rails for positioning or support, side	F 221	3. Facility staff has been re-educated (by social service director and QI) on the proper reporting procedures when residents' express concerns. As per the facility policy all resident, family or visitor concerns will be investigated and the outcome of the investigation reviewed with the affected individual to ensure resolution of the problem. 4. The administrator will review all grievances filed to ensure a thorough investigation has been completed. Results will be presented at the QI meeting monthly and tracked/ trended to identify potential patterns for additional corrective action. 5. Date of compliance will be 1/23/2012 **F-tag 221 Restraints** 1. A follow-up side rail assessment was completed for Resident # R35. The bed bolsters were removed, as were the side rails. The resident was placed in a low bed with a perimeter mattress and mats beside the bed.	1/23/12

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F 221	Continued From page 2 rails are indicated to provide safety as protection, and to promote independence. Throughout the survey several observations were made by the surveyor of R35 lying in bed with 2-1/2 upper side rails (3 feet 3 inches long) in place and 2 large bolsters (over 34.6 inches long and 7 inches tall) down the lower sides of his bed. R35 demonstrated that he could move his left arm and hand and had some movement of his left leg. He was unable to move the right side of his body. On 12/8/11 at 1:05 PM E8 (CNA) stated R35 had two upper side rails in place along with two large bolsters down the lower side of the bed to prevent R35 from getting out of bed. E8 continued to state that R35 could scoot his bottom around and he could fall out of bed. To keep him from falling out of the bed we used the side rails and bolsters. E8 stated he has not moved around a lot or fallen in years. Interview with E4 (RN unit manager) on 12/12/11 at 9:00 AM revealed R35 had 2- 1/2 side rails and 2 large bolsters for safety to keep him from falling out of bed. However, he had not fallen in years. E4 confirmed that it was easier to have side rails and bolsters than staff to use a hoyer lift to pick R35 off the floor if he rolled out of bed. An observation of R35 in bed on 12/12/11 at 9:20 AM with E20 (treatment nurse) revealed she did not know why the resident had the bolsters as he has not moved around alot in bed for years. On 12/12/11 at 2:20 PM interview with E5 (RNAC) revealed the bed rails for R35 were	F 221	2. Repeat side rail assessments were completed for every resident in the facility that used side rails to identify the reason for their use and to review potential interventions to reduce the side rail use. 3. Side rail assessment form (Attachment A) was revised to more appropriately reflect the current definition of a restraint. Nursing staff has been re-educated regarding the completion of the side rail assessment form, (Side rail Assessment Policy and Procedure Attachment B) the definition of restraints and the use of alternative interventions in order to reduce the use of rails in the facility. Side rail assessments will continue to be completed on admission, re-admission, quarterly and when there is a significant change in the resident's condition. Residents that have been deemed to have the side rail as a restraint device will be reviewed monthly to ensure the appropriateness of the continued use of the rail and to review potential interventions for reduction of the device.	

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F 221	Continued From page 3 assessed on the MDS as a restraint. The side rails were used to prevent him from falling out of bed. E5 stated the bolsters were not necessary for this resident. On 12/13/11 E3 (ADON) stated the facility staff reassessed R35 and the bolsters were removed.	F 221	4. The RNACs will continue to audit residents' identified with restraints on a monthly basis and submit the report to the QI committee for tracking /trending for the need of additional corrective action. 5. Date of compliance will be 1/23/2012	1/23/12
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the activity calendar and interview it was determined that the facility failed to provide activities to meet the interests as identified in the facility's assessments for 3 (R35, R121, and R68) out of 40 sampled residents. Findings include: 1. R35 had diagnoses that included cerebral vascular accident, dementia with behaviors and diabetes mellitus. The annual MDS dated 12/7/11 documented R35 was cognitively impaired for daily decision making. It also documented that R35 had highly impaired vision and sometimes he understood others. Review of R35's care plan for "Requires visits to maintain awareness of others and environment"	F 248	**F-tag 248 Activities** 1. Resident # R35 was provided a television in his room and will be taken to activities outside of his room based on input obtained from the family regarding past preferences and will be taken to Sussex for appropriate cognition and sensory programs. Residents # R212 and R68 had their activity preferences reviewed by the Director of Activities and resident specific programs implemented including sporting events. 2. Resident preferences will be re-reviewed for all residents' on the Kent wing and programs offered based on the residents' preferences.	

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F 248	Continued From page 4 with strengths as alert and family support. The care plan approaches included visits weekly one to one and offer opportunity to participate in programs of interest: cards,TV, conversations..., assist as needed to pursue interest. R35's activity assessment dated 7/6/11 documented that he was alert and awake most of the day. He made eye contact and occasional verbal responses during interactions. "His TV and roommates is turned on daily." On 12/7/11 during the survey R35 was asked by surveyor if he wanted to go to activities. R35 shook his head "yes". The surveyor asked R35 several other questions in which R35 answered appropriately. Observations made throughout the survey revealed R35 was in his room located on the Kent unit, either in bed or in a geri chair. R35 did not have a TV of his own. However, his roommates TV was turned on, which was located on the opposite side of the room, for two of the 6 days observed. On 12/12/11 at 11:35 AM interview with E6 (Activity Director) confirmed that R35 did not have his own TV. The TV that was turned on for R35 belonged to his roommate. Surveyor asked why R35 was not taken to activities, especially the very active program provided by the facility for the cognitively impaired residents on the Sussex wing. E6 stated that R35 was in the Kent unit and she never thought to invite him to the Sussex unit activities. On 12/13/11 at 8:10 AM interview with E3	F 248	3. Resident preferences will continue to be reviewed at the time of admission, re-admission, annually and when there is a significant change in the residents' condition to identify potential changes in their preferences. Resident specific programs will be provided based on these reviews and will be updated with care conferences each quarter. 4. QI will randomly audit 10% of the residents preferred activity choices and compare their chosen preferences with the programs offered. Residents will be interviewed as part of this audit to determine satisfaction with the programs offered. The audit results will be tracked/ trended and present at the QI meeting monthly for the next six months. At that time the continued frequency will be re-evaluated based on the audit findings. 5. Date of compliance will be 1/23/2012	1/23/12

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F 248	Continued From page 5 (ADON) confirmed R35 did not have his own TV. The TV in his room belonged to his roommate. E3 continued to state that the facility will provide a TV for R35's use. 2.R121 was admitted to the facility with diagnoses that included hypertension, coronary artery disease and dementia. The admission MDS for R121 dated 11/11/11 documented he was moderately cognitively impaired for daily decision making. Review of R121's initial activity assessment dated 11/8/11 documented the following assessment: he liked sports baseball, football (steelers), bowling and golf. R121 liked to watch sports, news and games on TV. He liked sports magazines exercise and swimming. It continued to document that R121 was alert and oriented and awake most of the day. He interacted well and answered the assessment questions even when daughter disagreed with him. He had stated that he doesn't like being with groups of people and has few interest other than sports on TV and reading the sport magazine occasionally. Review of R121's Care plan for activities revealed he was to be offered opportunities to participate in programs of interest including sports and assist as needed to purse interest. Observations made of R121 during the survey revealed he was either sitting on his bed or in his chair. He did not have a sports magazine near him nor was his TV on a news or sports program. 3. Review of R68's quarterly MDS dated 9/1/11	F 248	**F-Tag 253 Maintenance** 1. The maintenance department conducted a resident room review for the entire facility to identify damaged veneer. 2. The damaged veneer of the woodwork located under the sinks in the identified rooms will be replaced by 1/23/2012. The facility is in the process of retaining the services of a contractor to repair/replace any damaged veneer for all remaining rooms. 3. All staff were re-educated on the completion of maintenance request forms when issues are identified. Routine facility room audits will be completed bi-annually by the maintenance supervisor to identify future maintenance issues that need to be corrected and an action plan for correction established and submitted to the administrator. 4. Random maintenance audits will be completed of 10% of the resident's rooms (on a rotating basis to ensure that different rooms are reviewed each month) monthly for the next six months by the Housekeeping Supervisor.	

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F 248	Continued From page 6 revealed he was cognitively intact. On 12/9/11 at 11:10 AM R68 stated during an interview that he wanted sports as an activity. He stated he asked for sports to be added to the activity program but the facility staff just ignored him. R68 stated they took us to a game this summer and the bus was full. That should have told them we like sports as an activity. Most of the activities here were geared for the women. Review of the activity program that is located in the activity room for October, November, and December revealed Wii bowling was scheduled for November 10th and December 29th, 2011. No other sports related activities were available. An interview with E8 (Activity Director) on 12/9/11 at 11:25AM confirmed the facility provides Wii bowling as a sport activity. E8 stated she will add more sports to her activity calendar for the residents.	F 248	(attachment C– one requisition form will be completed for each room reviewed, the yellow copy to maintenance for repair, white copy to administrator, and pink copy will be retained for audit purposes) The audit results will be tracked/ trended and present at the QI meeting monthly for the next six months. At that time the continued frequency will be re-evaluated based on the audit findings. **F-Tag 279 Care Plans** 1. Resident # R35 after the side rail assessment was re-done care plan interventions were then updated to reflect the changes (low bed, perimeter mattress and floor mats) made and the elimination of the side rails. 2. Care plans were reviewed after the repeat side rail assessments were conducted for every resident in the facility using side rails to ensure that the rails were properly coded and included on the care plan when necessary.	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made in resident rooms, it was determined that the facility failed to provide maintenance services to provide a homelike environment. Findings include: 1. On 12/06/11, the veneer of the wood work	F 253		

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F 253	Continued From page 7 located under the sinks in the following rooms had water damage or wheelchair scuffs and scrapes; 47, 48, 49, 50, 51, 57. Follow-up observation on 12/13/11 confirmed this finding. 2. On 12/13/11, the veneer of the wood work located under the sinks in the following rooms had water damage or wheelchair scuffs and scrapes; 31, 32, 33, 36, 37, 38, 40, 41, 42, 43, 45, and 57. This represented 17 rooms observed out of 56 resident rooms in the facility.	F 253	3. Care plans will continue to be reviewed and updated as necessary when side rail assessments are completed. Care plan reviews will continue to be completed on admission, re-admission, quarterly and when there is a significant change in the resident's condition. Residents that have been deemed to have the side rail as a restraint device will have their care plan reviewed monthly to ensure the appropriateness of the continued use of the rail and to review potential interventions for reduction of the device. 4. The RNACs will continue to audit residents' identified with restraints on a monthly basis and submit the report to the QI committee for tracking /trending for the need of additional corrective action. 5. Date of compliance will be 1/23/2012	1/23/12
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	**F-tag 309 Quality of Care** 1. The unit manager re-educated the nursing staff regarding off-loading the heels for Resident # R35. Heels are now off-loaded.	

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F 279	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to develop a care plan for the use of restraints for one (R35) out of 40 sampled residents Findings include: Cross refer F222 R35 was admitted to the facility with diagnoses that included cerebral vascular accident, hypertension, dysphasia, seizure disorder and diabetes mellitus. The annual MDS dated 12/7/11 for R35 documented he was totally dependent with one person to physically assist him with his bed mobility.The MDS also assessed R35 as having 2 side rails as a restraint in bed. The December 2011 monthly physician orders for R35 revealed an order for "1/2 side rails special instructions: 1/2 Side rail up times 2 as safety measure related to poor trunk control and poor posture in bed. R35 demonstrated that he could move his left arm and hand and had some movement of his left leg. He was unable to move the right side of his body At different days and times during the survey R35 was observed in bed with 2 1/2 side rails up and 2 large bolsters down the bottom sides of his bed. R35 was unable to get out of bed. An interview with E5 (RNAC) on 12/12/11 at 11:35 AM confirmed the facility assessed R35's	F 279	The tray card for Resident # R104 has been updated to reflect current foods that will be excluded from her diet. The facility's menu cycle has been reviewed by the speech therapist to identify any other potentially problematic foods that are routinely served on a mechanical soft diet ordered for the resident. The resident was reviewed by the interdisciplinary team and a GI study, neurological consult and psychiatric consult will be requested to determine if there are other underlying causes for the resident's choking episodes. She will continue to be provided meals in a supervised environment and the unit manager will review the dietary restrictions with the family that provides outside food to the resident. 2. The unit managers and charge nurses will review the other residents' to ensure that the care listed on the 'Care Needs Quick Reference" (Attachment D) was provided. Direct care staff will be re-educated for any residents' identified that did not have proper devices in place.	

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F 279	Continued From page 9 bed rails as restraints however, they failed to develop a care plan for R35's side rails that were used and assessed as restraints.	F 279	Diet cards for residents that were identified with aspiration precautions or a history of aspiration in the past 30-days will be reviewed to ensure accuracy of the diet card with the physician's order and the care plan.	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview it was determined that the facility failed to ensure that two (R104, R35) out of 40 sampled residents received the care and services necessary to attain their highest practicable level of well being in accordance with the comprehensive assessment and plan of care. R104 was assessed for choking with meals resulting in a diet change that included no pancakes or bread products. Despite this assessment R104 was served waffles and began choking requiring life saving procedures that included the Heimlich maneuver and aggressive suctioning. R35 was assessed for being at risk for pressure ulcers. R35 was observed in bed for several days with his heels not off loaded. Findings include: 1. R104 had diagnoses that included anemia, chronic obstructive pulmonary disease, dementia, depressive disorder, diabetes mellitus, suicidal	F 309	3. Unit managers will re-educate their staff regarding the importance of following the care listed on the "Care Needs Quick Reference." (Refer to attachment D) QI Director will provide a general nursing inservice regarding proper care and treatment to prevent pressure and use of pressure relieving devises. The Skin Impairment Prevention and Treatment policy and procedure was updated to include the various levels of risk associated with potential skin breakdown (Attachment J). The unit managers will complete walking rounds of the unit daily to observe care provided. The Charge nurses will complete audits of the "Care Needs Quick Reference" every shift for the next eight weeks and then each	

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F 309	Continued From page 10 ideation, and dysphagia. The annual MDS dated 4/28/11 and quarterly MDS dated 9/29/11 revealed R104 required set up help and supervision for eating. R104's November 2011 Physician orders signed on 10/18/11 revealed she had a diet order for mechanical soft and was on Aspiration precautions. Nurses notes dated 10/4/11 at 8:07 AM documented that R104 coughed and choked on pancakes but was able to clear her airway on her own. The nurse continued to document that a Dietary Communication Form was sent to Dietary indicating not to send pancakes for R104. A speech therapy communication form was sent to screen the resident. A dietary note dated 10/6/11 documented that R104 was "coughing/choking on pancakes. Resident experienced a choking episode on a pancake again therefore they have been discontinued from her diet." The speech therapy care plan dated 10/10/11 revealed "Pt (patient) will tolerate mechanical soft diet with thin liquids without signs or symptoms (s/s) of aspiration. Patient seen by speech therapy for dysphagia (Inability to swallow or difficulty in swallowing. Taber's cyclopedic Medical Dictionary Ed. 19). Pt tolerated soft solids with thin liquids without s/s aspiration.... The facility documented on 3 different care plans (Therapeutic Diet, Mechanically Altered Diet and Aspiration Precautions) an approach of No Bread	F 309	shift monthly for three months to ensure care is provided as specified. (Attachment E Resident Care Rounds Audits) Any resident that exhibits swallowing difficulties with food intake will be referred to speech therapy. The speech therapist will complete a communication form (Attachment F) for any screen/evaluation findings and provide it to nursing. The speech therapist will review all recommendations verbally with the unit managers/designee. The unit manager will update the care plan with any recommendations and send a dietary communication form to dietary to update the meal cards when necessary. QI will re-educate the nursing staff, dietary staff and therapy staff regarding the communication process and diet card coding. Speech therapy will continue to review screens and evaluations completed each week with the interdisciplinary team at the weekly meeting.	

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F 309	Continued From page 11 products dated 11/7/11 for R104. This approach for No Bread Products was also documented on the outside of the care plan folder for quick review along with Aspiration Precautions. On 11/8/11 a physician order was written for Speech Therapy training to extend services due to dysphagia. Review of R104's Speech therapy note dated 11/16/11 revealed she was to continue with a mechanical soft diet and no bread products. R104's nurses notes revealed on 11/20/11 at 8:40 AM R104 began choking on breakfast at 8:20 AM. The nurse saw resident was having trouble expelling what was caught in her throat. The Heimlich maneuver was performed unsuccessfully. Suctioning was started. R104 was suctioned with a 14 french naso tubing on the 4th attempt some food bolus came loose. They reattempted with the yanker and a large food bolus was removed. R104 was able to take deep breath and stated she could breathe much better. An interview conducted with E10 (Dietary) on 12/5/11 revealed E10 was on the tray line on 11/20/11. When R104's tray came down the line, E10 told the cook (E11) that R104 was on a Mechanical soft with no bread. The cook told her she could have pancakes. E10 told the cook R104 could not have bread. The E11 (cook and E10's supervisor) told her to give R104 the waffle. An interview was conducted with E11 (cook) on 12/5/11. E11 stated she thought R104 did not want bread but it did not click the waffle was a	F 309	4. Audit results on the 'Care Needs Quick Reference" will be submitted to the Assistant Director of Nursing/QI Coordinator when completed for tracking/ trending. The audit results will be presented at the QI meeting monthly for the next five months. At that time the continued frequency will be re-evaluated based on the audit findings. The licensed staff assigned to the dining room will monitor that residents are serviced diets as per the diet card. (Attachment C – Dining Room Observation Audit) The dietitian will audit the diet cards with each record review to ensure that they match the therapy recommendations and physician orders. Her findings will be provided to the dietary manager for corrective action when necessary. The dietitian audits will be tracked/ trended by the dietary manager and submitted to the QI meetings monthly for the next six months. At that time the continued frequency will be re-evaluated based on the audit findings.	

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F 309	Continued From page 12 bread product. E11 confirmed she put the waffle on R104's tray. An interview with E9 (CNA) on 12/5/11 revealed she read the card and it said no bread products in the middle of the card. At the bottom of the card it had some foods that R104 could not have and pancakes was one of them. The card did not say "no waffles" so E9 stated she thought R104 could have the waffle. E9 stated she cut up the waffles for R104 and gave her the tray. A few minutes later R104 began choking on the waffle and the nurse was called. The nurse (E7) began doing the Heimlich maneuver. Interview with E7 (LPN) on 12/13/11 at 8:50 AM revealed the CNAs were yelling someone was choking while pulling the alarm. E7 stated she was doing her medication pass. She stopped ran in and began doing the Heimlich maneuver that was unsuccessful. So R104 was suctioned with the nasal cannula and yanker in order to dislodge the waffle. Interview with E18 (RN unit manager) on 12/12/11 at 9:00 AM confirmed R104 had a care plan indicating she was not to receive bread products/pancakes. Dietary staff and a CNA gave R104 the waffle which is considered a bread product. R104 began choking requiring the staff to perform the Heimlich maneuver. The staff also suctioned R104 to dislodge the food. While R104's care plan and communication slips between speech therapy, dietary and nursing identified R104's difficulty with swallowing the facility failed to incorporate this information into specific Physician orders. The physician order	F 309	5. Date of compliance will be 1/23/2012 **F-Tag 322 Naso-gastric Tubes** 1. The unit manager re-educated the nursing staff regarding the need to keep the head of the bed elevated for Resident # R35 when the tube feeding is running. If the staff need to lay the resident flat for care the charge will be notified to temporarily turn off the tube feeding while care is provided. The head of the bed will remain elevated during administration of the tube feeding. 2. The unit managers and charge nurses will review the other residents' with tube feedings for proper positioning of the bed during feedings. Direct care staff will be re-educated for any residents' identified that did not have the head of the bed elevated. 3. Unit managers will re-educate their staff regarding the importance of following the care listed on the "Care Needs Quick	1/23/12

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F 309	Continued From page 13 was not changed in order to modify R104's mechanical soft diet to exclude bread products. This lead to R104 choking requiring life saving measures that included the Heimlich maneuver and aggressive suctioning to remove the air way obstruction. 2. R35 was admitted to the facility with diagnoses that included cerebral vascular accident, hypertension, dysphasia, seizure disorder and diabetes mellitus. The annual MDS dated 12/7/11 for R35 documented he was totally dependent on staff for all his activities of daily living. R35's MDS documented that he required one person to physically assist him with bed mobility. On 12/4/11 a pressure ulcer prediction assessment was completed using the Braden scale. This assessment documented that R35 scored a 13 making him a moderate risk for acquiring pressure ulcers. Review of R35's care plan for skin break down documented approaches/interventions that included to float heels at all times. The following observations were made during the survey of R35's heels not being floated: 12/6/11 11:15 AM in geri chair heels not floated 12/7/11 3:20 PM in bed with heels not floated 12/8/11 12:45PM in geri chair heels not floated 12/9/11 in bed all day sheets pulled back heels not off loaded An observation of R35 and interview with E20	F 309	Reference." (Refer to attachment D) QI Director will provide a general nursing inservice regarding proper care and treatment for residents with naso-gastric tube feedings. The unit managers will complete walking rounds of the unit daily to observe care provided. The Charge nurses will complete audits of the "Care Needs Quick Reference" every shift for the next eight weeks and then each shift monthly for three months to ensure the head of the bed is elevated as specified. (Attachment E- Resident Care Rounds Audits) 4. Audit results will be submitted to the Assistant Director of Nursing/ QI Coordinator when completed for tracking/ trending. The audit results will presented at the QI meeting monthly for the next five months. At that time the continued frequency will be re-evaluated based on the audit findings. 5. Date of compliance will be 1/23/2012	1/23/12

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F 309	Continued From page 14 (treatment nurse) revealed R35's heels were not floated. E20 assessed R35's mobility. R35 left arm moved purposely, left leg some contracture of knee with limited movement, and his right side of his body had no movement with contractures. E20 also looked at R35's heels and observed that his right heel had red blanching. Review of R35's nurses notes dated 12/12/11 at 9:30 AM stated Resident has 0.4 x 0.4 x0 cm. Intact red blanchable area to right heel...nursing measure start puffy boots to bilateral feet at all times and off load heels at all times. During and observation and interview with E3 (ADON) on 12/13/11at 6:15 AM it was observed that R35's heels were not floated. E3 immediately instructed the CNA to float his heels. Review of the facility's policy and procedures for Skin Impairment Prevention and Treatment with E3 revealed the facility had a policy and procedure was documented for residents that scored at high risk for pressure ulcers. There was not a policy and procedure for residents that are assessed as being moderate or low risk for pressure ulcers.	F 309	F-Tag 323 Accidents and Supervision 1. The unit manager re-educated the nursing staff regarding proper transfer procedures for Resident #R35. A hoyer lift will continue to be used with two-staff members when transferring the resident. 2. The unit managers and charge nurses will review the other residents' to ensure that the care listed on the 'Care Needs Quick Reference" was provided appropriately including the amount of assistance with resident transfers. Direct care staff will be re-educated for any residents' identified that did not have proper transfer procedures followed.	
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322	3. Unit managers will re-educate their staff regarding the importance of following the care listed on the "Care Needs Quick Reference." (Refer to attachment D QI Director will provide a general nursing inservice regarding proper care and staff assistance with transfers. The unit managers will complete	

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F 322	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on record review, the facility's policy and procedures and observation it was determined that the facility failed to provide services to ensure one (R35) out of 40 sampled residents received care and treatment to help prevent aspiration for this tube fed resident. Findings include: The facility's policy and procedures for "Aspiration" Residents who are at risk for aspiration will be identified and provided by staff the necessary care and services to decrease their risk for aspiration. R35 was admitted to the facility with diagnoses that included cerebral vascular accident, hypertension, dysphasia, seizure disorder, diabetes mellitus, and was receiving a tube feeding. The annual MDS dated 12/7/11 for R35 documented that he was totally dependent on staff for all his activities of daily living including eating. R35's MDS documented that he required one person to physically assist him with bed mobility and personal hygiene. The monthly physician order sheet dated December 2011 for R35 revealed an order for "Elevate head of bed 30-45 degrees during feeding and one hour after." Review of R35's care plan for Aspiration Precautions documented approaches/interventions that included 13. Keep head of bed elevated 30-45 degrees during	F 322	walking rounds of the unit daily to observe care provided. The Charge nurses will complete audits of the "Care Needs Quick Reference" every shift for the next eight weeks and then each shift monthly for three months to ensure care is provided as specified. (Attachment E- Resident Care Rounds Audits) 4. Audit results will be submitted to the Assistant Director of Nursing/QI Coordinator when completed for tracking/ trending. The audit results will presented at the QI meeting monthly for the next five months. At that time the continued frequency will be re-evaluated based on the audit findings. 5. Date of compliance will be 1/23/2012 **F-tag 371 Food Preparation and Sanitation** 1. No specific residents were identified. 2. The QI Director re-educated nursing staff on proper hand washing and use of gloves when handling resident food.	1/23/12

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F 322	Continued From page 16 feeding and one hour after feedings. On 12/8/11 between 12:55-1:05 PM E8 (CNA) was observed providing incontinence care to R35 who was lying in bed. R35's tube feeding was infusing at 60 cc/hour with the head of his bed flat. The head of his bed was not elevated 30-45 degrees. This information was discussed with E3 (ADON) on 12/13/11 at 8:25 AM.	F 322	3. A dining room meal monitoring form was implemented. (Attachment G– Dining Room Observation Audit) The licensed staff were re-educated on the meal monitoring process to ensure that all aspects of the meal delivery have been provided appropriately. The licensed nurse monitoring each dining room will complete the meal monitoring form every meal two days per week and submit to the Assistant Director of Nursing for review, tracking and trending. The nurse monitoring the meal delivery will address any concerns observed with the pertinent staff and record such corrective action on the meal monitoring form. 4. The Assistant Director of Nursing will present audit results at the QI meeting monthly for the next five months. At that time the continued frequency will be re-evaluated based on the audit findings. 5. Date of compliance will be 1/23/2012	1/23/12
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review and observation it was determined that the facility failed to provide an environment free of accident hazards for one (R35) out of 40 sampled residents who was transferred from his geri chair to his bed by one person instead of two persons using a mechanical lift. Findings include: R35 was admitted to the facility with diagnoses that included cerebral vascular accident, hypertension, dysphasia, seizure disorder and diabetes mellitus.	F 323		

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F 323	Continued From page 17 The annual MDS dated 12/7/11 for R35 documented that he was totally dependent with two staff members to physically assist with his transfers. Review of R35's care plan for ADL (activities of daily living) had approaches/interventions that included 9. Transfer with mechanical lift with 2 person assist. R35's care plan for fall risk had approaches/interventions that included 6. Transfer mechanical lift with 2 person assist. On 12/8/11 the surveyor entered R35's room and observed E8 (CNA) putting R35 in bed. There was no mechanical lift or second person in the room to assist her with this transfer. This information was discussed with E3 (ADON) on 12/13/11 at 8:25 AM.	F 323	**F-tag 431 Medication labeling and storage** 1. No specific residents were identified. 2. All medication and treatment cards were reviewed to ensure that there were no additional outdated medications or creams present. Any outdated medication will be discarded as per the facility policy. The medication room doors will remain locked and access provided to licensed staff or consultants employed by the facility. Nursing staff was re-educated regarding medication room security. 3. The treatment nurse will review the ointments, creams, etc. present in the treatment cart once a week to ensure there are no outdated medications present. The primary medication cart nurses will review all of the medication carts weekly to ensure that there are no outdated medications present. Any outdated medication will be discarded as per the facility policy. Each nurse will sign that the review	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to serve food in a sanitary manner. Findings include:	F 371		

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F 371	Continued From page 18 On 12/6/11 between 12:00 and 12:30 PM during the lunch observation aide E19 , was observed touching R79's sandwich bread with her bare hand. The aide also touched the lettuce and the tomato with her bare hands as she added it to the sandwich. E19 then assisted R6 by touching her tomato, lettuce and sandwich bread with her bare hands. A few minutes later while feeding another resident, E19 stopped to assist R66 with her sandwich by taking it from her with her bare hands, fixing the contents and handing it back to the resident with bare hands. At no point during the observation did E19 wear gloves or wash her hands. These findings were reviewed with facility administration on 12/14/11.	F 371	has been completed. (Attachment H– Medication Labeling and Storage Audit) 4. The unit managers will audit compliance with the checklists weekly for the next eight weeks and then monthly for three months to ensure the audits are completed. Random reviews of the medication and treatments carts will be conducted by the Assistant Director of Nursing each month and negative findings reviewed at the QI meeting. Medication and treatment cart audit results will be submitted to the QI Coordinator when completed for tracking/ trending. The audit results will presented at the QI meeting monthly for the next five months. At that time the continued frequency will be re-evaluated based on the audit findings. 5. Date of compliance will be 1/23/2012	1/23/12
F 431 SS=B	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431		

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F 431	Continued From page 19 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure medications were properly stored and labeled. The facility also failed to ensure medications were not accessible to non-licensed staff. Findings include: 1. On 12/12/11 at 1:04 PM on the Kent Unit the treatment cart contained a tube of hemorrhoid cream that expired in September 2011. 2. On 12/12/11 at 3 PM on the Sussex Unit in the medication room a bottle of cough syrup that expired in August 2011 was found. There were also three bottles of opened insulin that were not labled with an open or discard date. 3. The facility's policy for Medication Storage in the Facility stated "The medication supply is accessible only to license nursing personnel,	F 431	F-Tag 441 **Infection Control** 1. No specific residents were identified. 2. The line-listing form used to track the facility infections was revised to include a column for the organism to be recorded. (Attachment I - Infection Control Report) 3. The infection control nurse will complete the line-listing form each month and submit to the QI meeting for review. The Director of Nursing will audit the infection control report each month for proper completion. 4. Date of compliance will be 1/23/2012	1/23/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085029	A. BUILDING _____ B. WING _____	C 12/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON HOUSE OF GEORGETOWN	110 W. NORTH STREET GEORGETOWN, DE 19947

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F 431	Continued From page 20 pharmacy personnel, or staff members lawfully authorized to administer medications." On 12/12/11, E17 (Medical Records and Storage staff) was observed obtaining the keys to the medication room from E18 (Registered Nurse) and E17 proceeded into the medication room unsupervised for approximately 15 minutes from 10:45 AM to 11 AM. Observations of the Sussex Unit medication room on 12/12/11 and 12/13/11 noted medications accessible in cabinets, fridge and containers on the counter top. An interview with the Associate Director of Nursing, E3 on 12/13/11 confirmed that E17 does go into the medication rooms to stock supplies and she should be supervised by licensed staff when in the medication room.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441		

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F 441	Continued From page 21 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on review of clinical record, facility documentation, and staff interviews, it was determined that the facility failed to document and trend infections within the facility from September 2011 through November 2011. Findings include: Review of the facility infection control program documentation revealed that for the months of September 2011 through November 2011, the type of organisms infecting residents were not consistently tracked. This lack of information prevented the facility from trending the organisms to determine if there was a pattern of infection that the facility needed to address. An interview with E16 (Quality Improvement	F 441		

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F 441	Continued From page 22 Director) on 12/13/11 at approximately 2:30 PM confirmed that surveillance tracking for the above period of time lacked the type of organism.	F 441		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Harrison House of Georgetown

DATE SURVEY COMPLETED: December 14, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced, annual survey and complaint visit was conducted at this facility from December 6, 2011 through December 14, 2011. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred-two (102). The survey sample totaled forty (40) residents	**Disclaimer** Preparation and/or execution of the Plan of Correction does not constitute an admission or agreement by the provider or the provider's employees as to the truth of the allegations in the Statement of Deficiencies. The Plan of Correction is offered in mandatory compliance with the provisions of state and federal law. The corrective actions are implemented as remedial measures pursuant to law.
3201	**Regulations for Skilled and Intermediate Care Facilities**	Cross reference to CMS 2567-L plan of correction submitted for tags F166, F221, F248, F253, F279, F309, F322, F323, F371, F431, and F441
3201.1.0	**Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.**	Date of Compliance 1/23/12

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

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3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Harrison House of Georgetown

DATE SURVEY COMPLETED: December 14, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey report date completed 12/14/11, F166, F221, F248, F253, F279, F309, F322, F323, F371, F431, and F441.	

Carole Dawson Administrator 1/6/12